

HEALTH HOME PROGRAM

OVERVIEW

Health Home is a person-centered care management model designed to address a recipient's medical, behavioral health and social service needs by forming a team of health care professionals around the recipient. At the center of a Health Home is a dedicated care manager who oversees and coordinates the services a recipient needs for optimal health status. The provision of appropriate care management reduces avoidable emergency department visits and inpatient stays and improves health outcomes. With the recipient's consent, health records are shared among providers to ensure that the recipient receives needed unduplicated services.

Health Home services are provided through a Designated Provider selected by the recipient or assigned by the state. The Health Home Program is one of two of South Dakota Medicaid's Care Management programs. The other Care Management Program is the Primary Care Provider Program. Recipients cannot be part of both programs at the same time but may move between the two programs if eligible. Providers may be both a Health Home designated provider and a primary care provider in the Primary Care Provider Program.

ELIGIBLE PROVIDERS

Designated providers for Health Homes include providers licensed by the State of South Dakota who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physician assistants, a mental health professional working in a Community Mental Health Center, or an advanced practice nurse practitioner working in a Federally Qualified Health Center, Rural Health Clinic, Indian Health Service Unit (IHS) or clinic group practice.

The designated provider leads a team of health care professionals and support staff that may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care coordinator/care, chiropractor, pharmacist, support staff, and other community-based services or professionals as appropriate.

Clinics can apply for Health Home status at any time. New clinics are enrolled at the start of a new quarter. Existing Health Home clinics can add new designated providers at any time.

New Health Home Start Dates:

- January 1
- April 1
- July 1
- October 1

Once a Health Home application has been reviewed and approved, the Health Home provider will receive a letter of notification from South Dakota Medicaid indicating their status as a designated Health Home. Any contingencies to the designation will be identified and described in the letter. A contingently designated Health Home is required to respond within the timeframe specified in the letter with a plan

that addresses any contingencies to the satisfaction of South Dakota Medicaid to become officially designated.

Health Home Program Goals

A Health Home designated provider is the central point for directing patient centered care and is tasked with the following goals:

- Reducing avoidable health care costs, including preventable hospital admissions/readmissions and avoidable emergency room visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by addressing primary medical, specialist, long-term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services.

Health Home Qualifications

To qualify as a provider, Health Homes must:

- Enroll in the South Dakota Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in the Health Home Provider Standards and the Health Home Core Services definitions found on page 3-4.
- Directly provide, or arrange for the provision of, Health Home services. The Health Home designated provider remains responsible for all program requirements.
- Complete Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution prior to becoming a Health Home provider.
- Electronically report to the South Dakota Medicaid in the manner defined by South Dakota Medicaid information about the provision of Core Services and the outcome measures.
- Collaborate with South Dakota Medicaid on an as needed basis to evaluate and continually improve the South Dakota Health Home model to achieve accessible, high quality care, and demonstrate cost-effectiveness.
- Comply with [42 CFR Part 2](#) as it pertains to sharing data for recipients with substance abuse disorders.
- Attend all required Health Home trainings.
- Provide the services as outlined in State Medicaid Director Letter ([SMDL 10-24](#)):
 - Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
 - Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;
 - Coordinate and provide access to preventive and health promotion services including prevention of mental illness and substance use disorders;
 - Coordinate and provide access to mental health and substance abuse services
 - Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from transfer from a pediatric to an adult system of health care
 - Coordinate and provide access to chronic disease management including self-

management support to individuals and their families.

- Coordinate and provide access to individual and family supports including referral to community, social support and recovery services.
- Coordinate and provide access to long-term care supports and services
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as feasible and appropriate.
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes and quality of care outcomes.

Health Home Provider Standards

Under South Dakota's approach to Health Home implementation, a Health Home designated provider is the central point for directing patient centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up and improving patient outcomes by addressing primary medical, specialist, long term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services. General qualifications are as follows:

- Health Home providers must be enrolled (or be eligible for enrollment) in the SD Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in this HH Provider Standards document and the Health Home Core Services document.
- Health Home providers can either directly provide, or arrange for the provision of, Health Home services. The Health Home designated provider remains responsible for all program requirements.
- Health Home providers must have completed Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution, prior to becoming a Health Home provider.
- Health Home providers must electronically report to the State (in a manner defined by the Department of Social Services) information about how the Core Services are being met and the outcome measures.
- Health Home providers must work in concert with the South Dakota Department of Social Services, on an as needed basis, to evaluate and continually improve the South Dakota Health Home model as a means to achieve accessible, high quality care, and demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.
- Health Home providers must comply with 42 CFR as it pertains to sharing data for patients with substance abuse disorders.
- Health Home providers must attend all required Health Home trainings.
- Health Home providers must provide the services as outlined in the Medicaid Directors letter SMDL 10-24 including

- Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
- Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services including prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health and substance abuse services
- Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from transfer from a pediatric to an adult system of health care
- Coordinate and provide access to chronic disease management including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports including referral to community, social support and recovery services.
- Coordinate and provide access to long-term care supports and services
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as feasible and appropriate

Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes and quality of care outcomes.

Core Services Definitions

The South Dakota Health Homes Core Services are defined as follows:

1. Comprehensive Care Management

Comprehensive Care Management is the development of an individualized care plan developed by the designated provider with active participation from the recipient and all health care team members. The individualized care plan should delineate the intensity of care coordination needed to meet the needs of each recipient. The designated provider is responsible for providing for all of the recipient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals. The designated provider should provide same day appointments, timely clinical advice by telephone during office hours, and document clinical advice in the medical record. Comprehensive care management services may include but are not limited to the following:

- Designated provider uses clinical and claims information to assess potential level of participation in care management services.
- Designated provider assesses preliminary service needs including behavioral health needs; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes;

- Health Home Care Manager monitors recipients and population health status and service use to determine adherence to or variance from treatment plan;
- Health Home Health Coach develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
- Health Home Health Coach provides education to recipients on how to access care during office hours, appropriate utilization of urgent care and emergency room visits, specialty services and support services.

2. Care Coordination

Care coordination is the implementation of an individualized care plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The individualized care plan should delineate how the intensity of care coordination needed to meet the needs of each recipient will be implemented. The Health Home care manager or care management team is responsible for the management of the recipient's overall care plan. The Health Home should share key clinical information (problem list, medication list, allergies, diagnostic test results) with other providers involved in the care of recipients. If a recipient is being served in the primary care setting and has behavioral health needs the care management team will ensure that a behavioral health provider is part of the team. Vice versa, if a recipient with severe mental illness has co-morbid physical conditions the care management team will ensure that a primary care provider is part of the team. Specific activities may include, but are not limited to the following:

- Health Home Health Coach monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
- Health Home Health Coach coordinates and/or arranges services for the recipient;
- Health Home Health Coach conducts referrals and follow-up monitoring;
- Health Home Health Coach supports the recipient's compliance with treatment recommendations;
- Health Home Care Manager participates in hospital discharges; and
- Designated provider and Health Home Care Manager communicate with other providers and recipient/family members.

3. Health Promotion

Health promotion services encourage and support healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Health Home care manager or health coach will provide health promotion activities. Specific activities may include, but are not limited to the following:

- Health Home Health Coach provides health education to recipients and their family members specific to the recipient's chronic or behavioral health conditions;
- Health Home Health Coach develops disease specific self-management plans;
- Health Home Health Coach provides education regarding the importance of immunizations and screenings, child physical and emotional development; and

Health Home Health Coach promotes healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. Comprehensive Transitional Care (including appropriate follow up from inpatient to other settings)

Comprehensive transitional care services are a process to connect the designated provider team and the recipient to needed services available in the community. A defined member of the designated provider care team has overall responsibility and accountability for coordinating all aspects of transitional care. Specific activities may include, but are not limited to the following:

- Health Home Care Manager facilitates interdisciplinary collaboration among providers during transitions;
- Designated provider encourages the PCP's, recipients and family/caregivers to play a central and active role in the formation and execution of the care plan;
- Health Home Care Manager provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
- Health Home Care Manager collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community; and
- Health Home Health Coach shifts the use of reactive care and treatment to proactive health promotion and self-management.

5. Individual and Family Support

Recipient and family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes. A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments. Specific activities may include, but are not limited to the following:

- Health Home Health Coach advocates for recipients and families;
- Health Home Health Coach identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
- Health Home Health Coach coordinates or provides transportation to medically necessary services; and
- Designated provider or Health Home Care Manager provides information on advance directives in order to allow recipients/families to make informed decisions.

6. Referrals to Community and Social Support Services

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. The Health Home designated provider has responsibility for identifying available community-based resources and managing appropriate referrals. Specific activities may include, but are not limited to the following:

- Health Home Health Coach coordinates or provides access to recovery services and social health services available in the community (may include housing, personal need and legal services);
- Health Home Health Coach provides assistance to obtain and maintain eligibility for health care, disability benefits, etc.;
- Health Home Health Coach supports effective collaboration with community-based resources and
- Health Home Care Manager and/or Health Home Health Coach assess long-term care and other support services.

Health Homes must adhere to the Health Home provider qualification and standards, functional requirements, and guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS) in [\(SMDL\) #10-024](#), Health Home for Enrollees with Chronic Conditions.

DSS must be notified immediately if the following occur:

- Provider additions or deletions
- Transitional Care Contact changes

Notifications can be sent via mail, email or fax to:

Division of Medical Services
Health Homes Program
700 Governors Drive
Pierre, SD 57501
605.773.3495
Fax: 605-773-5246
Email: DSS.Medicaid@state.sd.us

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using the Medicaid [Portal](#)

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Health Home services are provided to Medicaid recipients with complex chronic health and/or

behavioral health needs. This population includes Medicaid and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria:

1. Recipients with two or more chronic conditions or recipients with one chronic condition who are at risk for a second chronic condition.
 - Chronic Conditions: Mental Health Condition, Substance Use Disorder Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, Musculoskeletal and Neck/Back disorders.
 - At-risk Conditions: Pre-Diabetes, tobacco use, Cancer, Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of drugs).
2. Recipients who have a Severe Mental Illness or Emotional Disturbance.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

RECIPIENT ENROLLMENT

Recipients are determined eligible based on claims data from the previous 15 months. Eligible recipients are then tiered using the Chronic Illness and Disability Payment System (CDPS). The claims data is also used to determine if recipients in Tiers 2-4 have continuity of care with an enrolled Health Home provider. Continuity of care is defined as having a history of care with that provider through claims data or as the individual's primary care provider. If continuity of care exists, the recipient is automatically assigned to that provider and are put in the Health Home Program after a 30-day waiting period, effective the first day of the following month. During the 30-day waiting period, recipients may opt out of the program if they do not wish to participate or they may change Health Home providers if they wish to have a different provider.

Recipients who do not have an identified continuity of care provider from the claims data are sent a letter requesting the recipient to pick a provider. The recipient can choose to opt out of the program. If the recipient does not pick a provider within the 30-day period, the recipient may be assigned to a provider.

Each month DSS publishes a caseload list on the Medicaid [Portal](#) that includes recipients assigned to the Health Home. Providers should regularly review the caseload list for newly assigned recipients, recipients that have opted-out of the program or lost eligibility.

Members of the Health Home team can use the [Portal](#) to perform many functions of the Health Home Program. These functions include the following

Reviewing and/or Printing Caseload Reports

A Caseload report provides important information about each recipient on each providers panel. There are three types of caseload reports available in the [Portal](#):

1. Printable Report which provides all of the information about each recipient in a format that can be printed;

2. The Recipient and Family Information which provides all of the information about each recipient in a format which can be exported to Excel and stored in an electronic format or exported into some other system; and
3. The Export to HIE which provides a limited set of information that can be exported into the Health Information Exchange to allow clinics to receive notifications on certain recipients.

Portal Instructions for Caseload Reports

Users with permission can pull a month caseload report using the following instructions.

1. Under Reports, Health Homes, Caseload
2. Select the report year and month
3. Select the type of report. Printable Report, Recipient & Family Information, or Export to HIE as they are defined above. The system will generate the BNPI for which the user has access and the User will need to either select a BNPI or BNPIs and then NPIs of the providers for which they wish to generate a caseload.
4. Click on Generate Report

Health Home Caseload

Report Year: 2018
Report Month: 12

☒ Printable Report
☐ Recipient & Family Information
☐ Export to HIE

Billing NPI	Servicing NPI	Clinic Id
1275553463 <input checked="" type="checkbox"/>	1003103664 <input checked="" type="checkbox"/>	1341 <input type="checkbox"/>
1326066796 <input type="checkbox"/>	1124083795 <input checked="" type="checkbox"/>	
1366471666 <input type="checkbox"/>	1275553463 <input checked="" type="checkbox"/>	
1376575514 <input type="checkbox"/>	1427463033 <input checked="" type="checkbox"/>	
1669508677 <input type="checkbox"/>	1679758858 <input checked="" type="checkbox"/>	

Generate Report

The system will generate the type of report or download you requested and display the report for the user to be printed or downloaded.

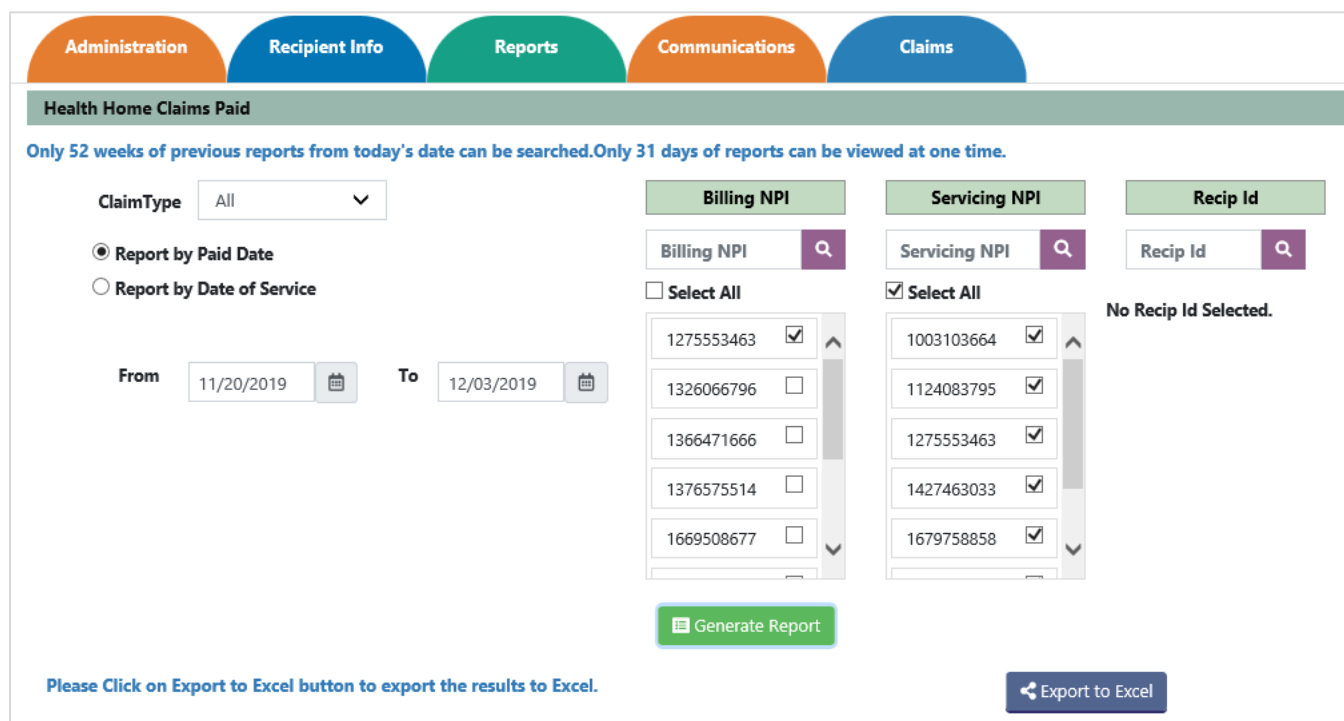
Claims Paid Report

The Claims Paid Report provides information about the claims filed for each recipient on the caseload report. This report can be generated by Claim Type and user can also choose to generate the report by paid date or date of service. Report can be generated for one provider or a group of providers under a BNPI.

Portal Instructions for Claims Paid Report

Users with Permission can also download the Claims Paid Report described above using the following steps.

1. Select Reports, Health Home, Claims Paid
2. Select All or choose specific claim types
3. Choose between Report by Paid Date or Report by Date of Service.
4. The system will display the accessible BNPI/s, select the BNPI/s to be displayed then either select all or specific Servicing NPI/s to be displayed. Claims can also be identified by recipient
5. Select Generate Report.
6. Select Export to Excel



Health Home Claims Paid

Only 52 weeks of previous reports from today's date can be searched. Only 31 days of reports can be viewed at one time.

ClaimType: All

☒ Report by Paid Date
☐ Report by Date of Service

From: 11/20/2019 To: 12/03/2019

Billing NPI

☐ Select All

1275553463	<input checked="" type="checkbox"/>
1326066796	<input type="checkbox"/>
1366471666	<input type="checkbox"/>
1376575514	<input type="checkbox"/>
1669508677	<input type="checkbox"/>

Servicing NPI

☒ Select All

1003103664	<input checked="" type="checkbox"/>
1124083795	<input checked="" type="checkbox"/>
1275553463	<input checked="" type="checkbox"/>
1427463033	<input checked="" type="checkbox"/>
1679758858	<input checked="" type="checkbox"/>

Recip Id

No Recip Id Selected.

Generate Report

Please Click on Export to Excel button to export the results to Excel.

Export to Excel

Recipient Opt-Out

Health Home recipients have the right to opt-out of the Health Home program using the [Decline to Participate](#) Form. Health Homes may complete this form based on a verbal request from the recipient that the recipient wishes to be removed from the program. Verbal requests must be documented in the Electronic Health Record. Forms must be faxed to (605) 773-5246.

Recipient Changing Health Homes

Health Home recipients may switch Health Home providers using the online selection tool at <https://dss.sd.gov/pcphhselection>. To complete a selection or change on this line you will need the Medicaid number, the Case ID and the Date of Birth. The Case ID can be found by using the Eligibility Inquiry functionality on the [Portal](#) or can be found on the caseload report. All changes go into effect on the first day of the following month. If the change is requested prior to the established cutoff date, the most recent Health Home provider assignment can be removed or ended at the end of the previous

month. If the request is received after the established cutoff date, the most recent Health Home provider assignment must remain and will be ended at the end of the month. If a provider, recipient, or caseworker can provide written documentation of a DSS error, or if a core service has not been provided, the most recent Health Home provider assignment may be removed. If payment has been made in error, DSS will work with the provider to recoup necessary payments. Documentation must be kept as appropriate.

Manual Tiering of Recipients

Health Homes may recommend recipients for the Health Home Program by completing the [Manual Tiering Document](#). The document must be accompanied by medical records that support the medical conditions indicated on the Manual Tiering Document. This allows the Department of Social Services to determine eligibility and tier in a consistent manner. Documents may be sent via mail, secure email or fax to:

Division of Medical Services
Health Homes Program
700 Governors Drive
Pierre, SD 57501
605.773.3495
Fax: 605-773-5246
Email: DSS.Medicaid@state.sd.us

COVERED SERVICES AND REQUIREMENTS

Health Home Core Services include:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
5. Individual and family support, which includes authorized representatives; and
6. Referral to community and social support services if relevant.

Health homes must use Health Information Technology (HIT) to link services as feasible and appropriate. Definitions of the six core service requirements are available on pages 4-6.

Health Homes are responsible for assuring that their recipients receive all medically necessary care, including primary, specialty, and behavioral health care either through direct provision of services or by referral to another provider. All referrals must be documented in the recipient's electronic health record. For more information on referrals please refer to the [Referrals](#) Manual. An example [referral form for CMHC Health Homes](#) is available.

Health Homes must provide same day appointments and 24 hour/7 day a week access by telephone to page an on call medical professional to handle medical situations during non-office hours. A plan for after-hour care must be communicated with the recipient and documented in the recipient's electronic health record. If the health home is affiliated with a calling network to serve as the after-hours contact,

this may be utilized for general information calls only. Any referrals given to recipients through a calling networks (e.g. referring recipients to seek medical attention in the emergency room) must be approved by the recipient's health home designated provider or designated covering provider.

NON-COVERED SERVICES

A core service cannot be claimed for outreach attempts to engage recipients in the Health Home Program. Core services may not be claimed for a service which may be individually billed to South Dakota Medicaid on a fee for service, daily or encounter rate.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Core Services

Health Home providers are required to maintain written documentation in the EHR that clearly documents the individualized care plan, supporting documentation for performance measures and core service requirements.

PERFORMANCE MEASURES

Health Home Performance Measures are a critical factor of determining the success of Health Homes. Performance Measures are made up of Clinical Outcome Measures, Process Measures, and Utilization Measures. Performance measures must be submitted for every recipient that the Health Home claimed a core service. In the absence of performance data, DSS will recoup the Per Member Per Month paid to the provider. Performance Measures and Data File Layouts can be found [here](#).

Performance Measures are reported to DSS on a biannual basis:

Submission Deadline	Data to be Submitted
February 28	July – December
August 31	January - June

Each Health Home will export the Performance Measure data in a file format outlined [online](#). DSS will pull claims data to complete the remaining Performance Measures.

QUALITY ASSURANCE REVIEWS

South Dakota Medicaid will conduct quality assurance by requesting portions of a recipient's EHR. The quality assurance reviews help ensure that Health Homes are meeting Health Home Requirements. Reviews may include, but are not limited to the following:

- Core Services are being provided as indicated;
- Care Plans are being developed and followed as appropriate;
- Appropriate Notifications and contacts are completed for the recipient; and
- Mental Health and Substance Abuse Screenings are completed for each recipient.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Reimbursement

Medical Services for enrolled Health Home Program recipients are reimbursed on a fee-for-service basis. Providers will also be paid a Per Member Per Month (PMPM) Payment on a quarterly basis. The PMPM is designed to cover items typically not reimbursable by Medicaid. The PMPM will be calculated based on the number of months the recipient was in the Health Home during the quarter, the tier of the recipient, and reported provision of a core service.

Each recipient in Health Homes must receive one core service per quarter. If a core service is not provided, the PMPM payment cannot be claimed by the Health Home.

Health Homes are required to complete the quarterly core service report through [Portal](#) at the end of each quarter by the indicated submission date:

Submission Date	Submission Period
April 30	January 1 – March 31
July 31	April 1 – June 30
October 31	July – September 30
January 31	October 1 – December 31

Portal Instructions for Completing the Core Services Report

Users with permissions can complete the Core Services Report using the following steps:

1. Reports, Health Home, Core Service Report
2. Select the Report year and the report quarter that needs to be completed.
IE 2019, April 1 – June 30
3. Select Generate Report.

Administration Recipient Info Reports Communications Claims

Health Home Core Services

This is an estimate of payment and may not reflect the actual payment if changes have been made outside of the Portal. This tool is to facilitate reporting.

Report Year 2018

Report Quarter April 1 - June 30

Generate Report

4. Complete the report by clicking on yes or no for each recipient.
5. Select submit. The Submit button will not open until all responses are complete.
6. User should receive a message indicating the report was successfully submitted.
7. Report should be downloaded and/or printed for future use.

For each recipient in the list, select yes or no to indicate whether a core service was provided for that person. Click the submit button to submit your responses.

Responses for the current quarter must be submitted by: 7/31/2018
Responses last saved on:
Responses last submitted on:

Total ESTIMATED payment:
\$0.00

Download
Print
Submit

Recip ID Recip Name Response Modified Name Date Search Reset

Billing NPI	Servicing NPI	Recipient ID	Recipient Name	Per Month Rate	Months of Eligibility	Total Estimated To Be Paid	Core Service Provided	Last Modified By	Modified Date	Locked
1275533463	1003103664	000178407	ARDEL STACIE A	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	000422830	BROOKS TAYLA L	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	000271260	BROWN EYES, PETE	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	000782116	BROWN, VERNON L	\$56.98	3	\$170.94	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	012054721	CASTLE, NICOLE R	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	000054582	CATCHES, EDELYN D	\$290.70	3	\$872.10	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	000047034	COMER, ROSE MARIE	\$56.98	2	\$113.96	<input type="radio"/> Yes <input type="radio"/> No			
1275533463	1003103664	020790711	COOK, DENISE L	\$33.72	3	\$101.16	<input type="radio"/> Yes <input type="radio"/> No			

The PMPM payment for Health Home Core Services will be made during the first full week after the due date of each quarterly core service report. Results of the payment can be found on the Remittance Advise also available on the [Portal](#).

Portal Instructions for Remittance Advice

Users with the appropriate permissions can access the Health Home Remittance Advice on the Portal using the following steps:

1. Select Reports, Health Home, Remit Advice
2. Select if you want a combined Remittance by BNPI, or Separate Remittance by BNP, SNPI
3. Select Date Range
4. Select Billing BNPI/s and Servicing NPI/s as appropriate
5. Select Create Report

Administration

Recipient Info

Reports

Communications

Claims

Health Home Remit Advice

Only 52 weeks of previous reports from today's date can be searched.

Please select whether you want to view all servicing NPI's in one file or individual files.

☐ Combined Remittance by BNPI
☒ Separate Remittances by BNPI / SNPI

Enter a date range (MM/DD/YYYY) to view your organization's information.

From To

Billing NPI

☒ Select All

1003208257 ☒

1003850884 ☒

1033242375 ☒

1043259930 ☒

1053311597 ☒

Servicing NPI

☒ Select All

1003208257 ☒

1568625531 ☒

1861479453 ☒

1225449226 ☒

1104087709 ☒

REFERENCES

- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. Can a provider disenroll from the Health Home Program?

Yes, unless it is a closure situation, a Health Home may discontinue providing Health Homes Services at the end of a quarter with a minimum of three months' notice to the Department of Social Services. Health Home services may not be discontinued without an approved closure/services cessation plan, which includes proper procedures for clinically appropriate recipient transition.

2. Can individuals who also have Medicare be a part of the Health Home Program?

Yes, however, the recipient must be eligible for full Medicaid coverage and meet the conditions to be eligible for the program. Qualified Medicare Beneficiaries (QMB) only and Specified Low-Income Medicare Beneficiaries (SLMB) only are not eligible for this program.

3. How do recipients get added to the caseload list?

Recipients are placed on caseloads in the initial attribution process if recipient meet the continuity of care requirement, the recipient can select a provider, or South Dakota Medicaid can assign them to a provider based on evidence in claims or past PCP Program history with the provider.

4. How do I remove a recipient from my caseload list?

There are two approved ways to remove individuals from your caseload lists without a recipient's permission.

- a. Inability to contact the recipient. Once the requirements outlined at <https://dss.sd.gov/docs/healthhome/disenrollment.pdf>, are met, a Decline to Participate Form can be submitted and the recipient will be removed according to the procedures outlined above.
- b. Behavior. Once the requirements outlined at <https://dss.sd.gov/docs/healthhome/recommendeddisenrollmentprocess.pdf>, are met, a Decline to Participate Form can be submitted and the recipient will be removed according to the procedures outlined above.

Providers can also facilitate a removal with a verbal request from the recipient.

5. How can I help recipients choose another provider?

Upon receipt of verbal request from a recipient, providers can help facilitate the switch to a different Health Home. A list of participating Health Home providers can be found at <http://apps.sd.gov/SW96PC01MED/Default.aspx?Code=H>. Use the PCPHH selection website <https://dss.sd.gov/pcphhselection> to help recipient choose a new PCP.

6. How can I get a new provider to show up in my permissions on the Medicaid Portal?

Permissions for the Medicaid [Portal](#) are clinic driven. To receive permission to a new provider, please contact the Provider Administrator in your clinic to ask for the new provider to be added to your list of permissions. If these permissions are not added you will not be able to see any caseloads or complete the core services report associated with the new provider.